



**Town of Reading**  
16 Lowell Street  
Reading, MA 01867

Fax: (781) 439-6018

Website: [www.ci.reading.ma.us](http://www.ci.reading.ma.us)

**Administrative Services**  
**Human Resources Division**  
781-942-9033

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## Health Insurance Opt-Out Program

### Eligibility

1. Benefit Eligible – To participate in the Opt-Out Program, an employee must be an active employee who is eligible for group health insurance benefits through the Town of Reading.
2. 24-months of coverage – An active employee must have been covered by a Town health insurance plan for at least 24 continuous months prior to his/her application to the Opt-Out Program.
3. Proof of other coverage – An employee must show proof of coverage outside a Town sponsored health plan before participating in the Opt-Out Program. Employees must fill out the state Health Insurance Responsibility Disclosure Form (HIRD) form and other necessary forms each year during the Town's Open Enrollment period.

### Opt-Out Guidelines

1. The only way to receive the Opt-Out is if the employee is not covered by the Town's health plans in any way (This includes through a parent or spouse's plan.) Changing from a family to an individual plan does not count.
2. The Opt-Out will have a sunset provision. We offered this program for two years, July 1, 2012 through June 30, 2014, on a trial basis. We will continue to offer it from July 1, 2014 through June 30, 2015. We will decide each year whether or not to continue to offer it. If the Town decides not to offer the Opt-Out Program anymore, employees will be given an opportunity to get back onto the Town's health plans if they choose.
3. Any issues or disputes that arise regarding enrollment periods or rules and regulations relating to the implementation of the program shall be reviewed by the Town Manager. His determination shall be final and binding.

### Timing of Application/Payment

Once an eligible employee waives coverage of his/her group health insurance plan through the Town, he/she will receive an annual incentive payment. Payment of the opt-out incentive will be at the end of

the plan year (currently the fiscal year). (Ex. Withdraw coverage effective July 1, 2014 and receive incentive payment in July 2015.) Such incentive payment shall not be considered part of or included in the employee's base pay and the incentive payment will be subject to deductions for state and federal taxes and other deductions required by law.

1. Open Enrollment – Generally, employees will apply for the opt-out program during the Annual Open Enrollment Period.
2. Spouse's Open Enrollment – Where an employee's spouse has a different open enrollment period, the employee can waive his/her group health insurance coverage during their spouse's open enrollment. Payment will be a pro-rated amount of the incentive at end of the plan year. Subsequent annual payments will be made at the end of each plan.
3. Qualifying Event – An employee can always waive his/her health insurance outside the Town's Open Enrollment period if she/he has a qualifying event. When such a circumstance arises an employee can participate in the Town's Opt-Out program. However, these individuals will not receive a payment during the plan year in which they initially waived their insurance but will receive the annual payments at the end of each subsequent plan year.

#### **Re-Enrollment in the Town's Health Insurance Plans**

An employee who enrolls in the Opt-Out Program may re-enroll in one of the Town's health insurance plans:

- A. During the Town's annual Open Enrollment period by contacting the Town's Human Resources Office and completing the required paperwork, or
- B. In the case of a loss of coverage, by contacting the Town's Human Resources Office within 30 days of the qualifying event and providing documentation of the loss.



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## **Voluntary Waiver of Health Insurance**

### **Opt – Out Health Insurance Program**

I, \_\_\_\_\_, hereby acknowledge that I have been advised of my right to enroll in health insurance coverage through the Town of Reading. Having been so advised, I do hereby waive my right to health insurance coverage through the Town and I authorize the Town to cancel my health insurance coverage as of July 1, 2014.

In return for my agreement to waive health insurance coverage, the Town agrees to pay me:

☐ \$1500.00 for waiving my individual health insurance plan

☐ \$3000.00 for waiving my family health insurance plan

- I hereby certify that there is no outstanding court order or agreement requiring me to provide health insurance coverage for my spouse, ex-spouse or dependant children, if any.
- I understand that the Town of Reading is not responsible for my medical coverage effective on \_\_\_\_\_ (except for medical coverage for injuries and illnesses covered by M.G.L. c. 41, 111F or M.G.L. c. 152) and for each fiscal year thereafter that I voluntarily agree to waive health insurance coverage through the Town.
- I hereby acknowledge that I am only eligible to re-enroll in the Town's health insurance plans during the Annual Open Enrollment Period or due to a loss of coverage from a source other than the Town. To re-enroll, I must complete the required paperwork during the Open Enrollment period or, for a loss of coverage, notify the Town Human Resources Office and complete the re-enrollment process within thirty (30) days of the date of loss of coverage.
- I acknowledge that if I do re-enroll in the Town's group health insurance or my employment with the Town ends through no fault of my own (resignation, retirement, reduction of hours or death) during the fiscal year, I will only be eligible for a pro-rated payment.
- I acknowledge that I have read and agree to comply with the terms and conditions of the Town of Reading's Opt-Out Program.
- I acknowledge that the opt-out payment will be subject to Federal, State and Medicare taxes and any other deductions required by law.
- We offered this program for two years, July 1, 2012 through June 30, 2014, on a trial basis. We will continue to offer it from July 1, 2014 through June 30, 2015. We will decide each year whether or not to continue to offer it.

\_\_\_\_\_  
Employee Name (Please print)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Carol B. Roberts  
Human Resources Administrator

\_\_\_\_\_  
Date

The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Division of Health Care Finance and Policy

## Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < [www.mahealthconnector.org](http://www.mahealthconnector.org) >.

Employers: please complete this section. See reverse side for instructions.	
<b>Employer</b>	<b>Employer Name:</b> <u>Town of Reading</u> <b>FEIN:</b> <u>04-600-1277</u>
	<b>Employer D/B/A:</b> _____
	<b>Employer Address:</b> <u>16 Lowell St</u>
	<b>City   State   ZIP Code:</b> <u>Reading, MA 01867</u>
	1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	2. Did you offer employer sponsored health insurance to this employee? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
	3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.) <u>\$198.89</u>
Employees: please complete this section. See reverse side for instructions.	
<b>Employee</b>	<b>Employee First Name</b> <input type="text"/> <b>Middle Initial</b> <input type="text"/>
	<b>Employee Last Name</b> <input type="text"/> <b>Suffix (e.g., Sr., Jr.)</b> <input type="text"/>
	1. Did you accept your employer sponsored health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> None Offered <input type="checkbox"/>
	2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> None Offered <input type="checkbox"/>
	3. Do you have other health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>

### Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L. c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

**Employee Signature**

**Date (MM/DD/YY)**

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The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.